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ABSTRACT

There are training dilemmas which are characteristic of medical settings. Clinical psychology students interning in a hospital setting are unfamiliar with the hospital culture, and the demands of patient care require a practical active approach. Experiences with training clinical psychologists to consult with pediatricians are reviewed. Disparate training backgrounds and problematic models of collaboration are seen as barriers to learning effective consultation. To meet these potential obstacles, training approaches should stress observation of staff interaction, participation in viable consultation structures and intensive clinical training. With optimal supervision, psychologists at a variety of levels can be trained to consult successfully with pediatricians. (Author/BN)

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# PROBLEMS AND PROSPECTS IN TRAINING PSYCHOLOGISTS TO CONSULT WITH PHYSICIANS

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In recent years, the expansion of psychological medicine has provided increasing opportunities for psychologists to work alongside physicians in a variety of hospital, university, and medical school settings. It is well recognized that traditional models of clinical training do not equip psychologists for this role. Graduate training does not usually emphasize collaboration with physicians, content areas related to physical medicine or health care, or expose students to physicians' work settings. For this reason, traditional clinical training must be modified to provide meaningful consultation experiences in medical settings. In this report, I would like to share our experiences in training clinical psychologists at a practicum level to work with physicians in a pediatric hospital. My paper will concern the obstacles which can impede effective training and a model of practicum training designed to meet some of these problems.

The training experience takes place in a large 220 bed childrens hospital, which is the teaching hospital for Case Western Reserve Medical School. Thus, the problems I will discuss have particular relevance to acute care hospitals.

The pediatric faculty's recognition seven years ago that consultation and clinical services should be provided by a psychologist based full-time in the hospital was an obvious first step in the eventual development of practicum training. This eventually led to the development of a variety of diagnostic

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and treatment services involving individual patients as well as liaison activities including regular consultation meetings with medical and nursing staff (Drotar, 1976; Drotar, 1977). After about a year, we had sufficient referrals and good will among the pediatric staff to support a training experience. We started slowly initially with a diagnostic rotation in pediatrics as part of our internship program. This rotation has continued up until the present time. Depending on the intern's interest and the structure of his/her program, the pediatric rotation may last 1-4 months and includes consultation with staff and psychological evaluation of children and adolescents. This experience was meant to give our interns exposure to a general medical setting but not to provide indepth training. For this reason, we sought to expand our training efforts in other areas. Practicum training seemed a likely possibility. The close physical proximity of the psychology department at Case Western Reserve was clearly an important advantage, and one which is not enjoyed by many medical centers, yet, the relationship between psychologists in the medical school and those in the department of psychology had been marked by mutual isolation. No practicum training was offered in the medical school and there was little interchange among the psychologists. Fortunately at this time, the psychology department was trying to expand clinical training and was searching for practicum experiences. This development fit with my own interests so we naively went ahead. I say naively because there were a number of problems with this training, which was initially conceived of as part of first year graduate students diagnostic practicum. Although the experience was not a total disaster (the students reacted positively to this experience) it was very difficult for students to keep pace with the demands of a busy inpatient pediatric service, where the average length of stay is 7 days. Our first year students were so busy learning the rudiments of test administration and interpretation, as well as wading through their first professional encounters with

children and their families that they could not effectively consult with pediatric and nursing staff in the setting. They seemed rather intimidated and overwhelmed by the staff and the setting. After a year, we elected to discontinue this model of practicum training but tried to learn from it in designing a new experience. To my mind, our abortive initial efforts underscored the training dilemmas that are characteric of medical settings which I would like to describe in more detail. For example, students are unfamiliar with the culture of a general or pediatric hospital which presents them with such a bewildering array of patients and professionals. The comments of one first year student who said he found the hospital "overwhelming, that he never knew that there were so many diseases and problems" underscores this dilemma. Students often have high expectations of physicians and are dismayed when they find that their expectations are not met; e.g. when they find that medicine is as much a clinical discipline as science. To work effectively in medical settings, students must adapt to a very foreign culture. The pace and style of academic psychology is very different from that of medicine. The demands of patient care and clinical responsibility require an active approach which is oriented to practical, rather than theoretical solutions to problems. Pediatricians are rooted in concrete, physical reality and often are impatient with abstract explanation. This places a significant demand on the beginning clinician to translate their work into practical applications. Students must also learn empathy for the pressures on physicians, but still be critical enough to question the maladaptive aspects of medical care. I think it is difficult for anyone to understand the perspective of another professional discipline without resorting to stereotypes. A suspicion of medicine (which is somtimes justifiable) permeates graduate training in psychology. As a result, the value of collaboration with physicians may not be sufficiently emphasized. Collaboration is complicated by the fact that pediatricians are

also trained by members of their own discipline and do not have a clear idea of the potential contributions of psychology. Psychology graduate students in general medical settings must also learn to deal with clinical problems that are given short shrift in many graduate programs. For example, the emotional and developmental problems of infants and preschool children are often seen in pediatric settings but are not emphasized in most practica. The neurological problems of childhood, the psychosocial problems associated with chronic physical illness and the management of emotionally based pain also present novel problems to clinicians trained in traditional settings. Thus, our students face a formidable task. They must somehow learn specialized clinical knowledge at the same time that they are learning the medical setting, culture, and the rudiments of consultation with physicians. We quickly learned that it is important for students to have at least some prior clinical training in their home department before they venture out into the pediatric hospital. Other problems in training students in medical settings surfaced. For example, pediatric settings have a high degree of work related stress. Children with acute and chronic, sometimes life threatening illness pose difficult stresses to seasoned professionals, let alone beginning students. Such work related stresses are often the primary reason that medical and nursing staff will refer patients for consultation. For example, patients with life threatening illness may be labeled as disturbed when they are actually undergoing a psychological crisis which is at least partially related to the medical treatments they are receiving. Angry parents may be labeled as pathological when they are reacting reasonably to a tragic situation. It is often difficult for medical and nursing staff to recognize the roots of parental concerns because they make the staff feel guilty about causing suffering. Expecting anyone, including students, to tackle such referrals without a suitable forum to address the staff's underlying concerns is generally counterproductive.

This raises another point. Our experience suggests that training is most effective in those areas where senior psychology staff have achieved harmonious collaboration with medical and nursing staff. Yet, as anyone who works in general medical settings will attest, viable models of consultation with physicians are difficult to achieve. The quality and level of collaboration between physicians varies greatly from setting to setting, physician to physician, and across medical subspecialties. For example, in some settings, psychologists may work quite independently of physicians, and have little contact except for referrals. In this model, physicians make referrals and receive a report without expecting psychologists to collaborate in diagnostic or treatment planning. In other settings, psychologists may be forced to function under narrow models of pediatric diagnosis and treatment which are more appropriate to the care of acute illness than complex psychosocial problems. In some so called teams, psychologists may be given or actually choose peripheral roles concerning patient care. Physicians may exert control over the team without really sharing responsibility for patient care. Such models of consultation are especially problematic in the treatment of chronic illnesses. When care is fragmented across many disciplines, the chronically ill child and his family may become increasingly anxious and confused. Further, chronically ill children's adaptational problems may relate as much to the inherent stresses of medical procedures or dysfunctional patient-physician relationships as they do to internalized conflict. To address such problems, we have found it helpful if the medical and nursing staff join the psychologist in regular dialogues about patient care. The psychologist must have the potential to help the staff make changes in their modes of operating, particular concerning the degree and quality of their communications with children and their families. What are the implications of all of this for training psychologists? We feel strongly that it is difficult to train students in limited models of consultation where

psychologists do not play an active role in patient care. It also seemed to us that practicum students needed a larger introduction to the setting and a more intensive experience. In line with our experience, we redesigned our practicum to run for two years and to provide a graded exposure to the setting. I would like to describe this experience in more detail.

The first year is designed as an introduction and observational experience. First year graduate students are exposed to supervised observations of hospital rounds, group oriented consultation, and diagnostic assessment in the pediatric setting. At the same time, students receive training in test administration, scoring and interpretation in a child clinical placement in another practicum setting. In the pediatric hospital, the training experience includes at least two hours of observations per week, a one hour weekly seminar devoted to the clinical problems found in the setting, and another hour of supervision and discussion. The observational experience now runs for two semesters. One important component of this experience is trainees' observation of psychosocial rounds with medical and nursing staff. In our setting, these rounds occur on selected inpatient divisions and specialty groups. For example, on our adolescent division, weekly psychosocial rounds have been established for a number of years and concern case management of adolescents with a variety of problems. Patients' suitable for discussion are screened with the head nurse and pediatric staff who then present a brief case history and observations. The staff psychologist contributes a preliminary formulation and recommendations for staff's interventions with children and their families. The meetings allow us to identify those patients needing psychological assessment or intervention. At the same time, these meetings have a broader function: the psychologist has a multifaceted role as moderator of group process, teacher concerning the management of common psychosocial problems and facilitator of intra-staff communications. Such meetings provide an excellent

opportunity for students to observe physician's and nursing staff's confrontation of psychosocial problems related to their work settings. Common problems on the young adult unit include the management of acting out adolescents, the psychological support of chronically and terminally ill patients and the management of adolescents in the midst of psychological crisis, such as those with suicidal behavior. The meetings often touch on staff's frustrations and anxieties about their work, and conflicts with one another, particularly those that intrude onto their work. In this way, students observe the work related dilemmas of physicians, and are thus acquainted with the heavy emotional burdens shouldered by pediatricians and nurses in their daily work. The meetings are supplemented by regularly scheduled supervisory meetings where students discuss their observations. These discussions allow clarification of students' feelings about the medical and nursing staff, and a beginning empathy for the staff's role.

Psychological consultation to the pediatric treatment program for children and adolescents with end stage renal failure offers students the chance to observe an alternative model of consultation. Over the past four years, our staff has evolved a family-oriented approach to patient care which involves long term, continuous psychosocial support to the families of children who undergo dialysis and transplant. Our program emphasizes family participation in medical treatment planning, recognition of ethical questions raised by medical treatment, psycho-educational and mental health planning. The weekly comprehensive care conference aids intra-staff communication and helps plan communications with families, and more intensive mental health interventions. Clinical consultation includes direct service to children and families who may be seen for crisis-oriented intervention, long term psychotherapy, and evaluation of academic achievement, intellectual development, or emotional status.

In their first year, trainees also have a chance to discuss consultation strategy in supervision. For example, one common consultation dilemma concerns

the manner in which the consultant gives input to staff. A rigidly didactic emphasis may prevent the staff from developing their own solutions to problems. On the other hand, the pediatric staff finds specific advice, particularly treatment recommendations helpful to their work. Working with the staff's emotional reactions to patient care or conflicts with one another poses another common consultation dilemma. If these problems are not addressed, patient care can be gravely affected. However, too much of an emphasis on these problems may be too threatening to the staff to be productive. As trainees become familiar with staff and feel comfortable, they begin to actively contribute, initially asking questions and then providing input of their own. These meetings also allow students to become familiar with staff and the staff to get to know them. This familiarity becomes particularly important once students start functioning more independently and carrying out assessments. The meetings eventually provide a forum for students to contribute their findings from their own evaluations of patients and their families.

As part of their observational experiences during the first year, students observe senior staff's assessments of children and families which include parent, family and child interviewing, intellectual assessment and projective tests. Supplemented by discussions of clinical issues stimulated by these assessments, these observations provide trainees with a role model and a feel for the varieties of clinical work in the pediatric hospital. Participation in a weekly seminar attended by staff and trainees from the mental health disciplines in pediatrics familiarizes students with the nature of clinical work in the setting. Recent seminar topics have included anticipatory grief, preparation of children for surgery, impact of surgery on body image and psychosocial intervention in chronic disease and physical handicap. The seminar focuses on case conferences presented by staff and trainees and occasionally includes literature review and research on health-related topics such as consultation in the medical settings, the impact

of chronic illness on the child and the family, and child abuse and neglect. These readings are meant to supplement the students academic work and aid their understanding of common topics in pediatric psychology.

The second year of the practicum is designed to provide students with an intensive clinical experience with the common problems in the pediatric setting. The bulk of the clinical experience is obtained through referrals from the medical staff. These referrals are screened to ensure that the questions can be answered through psychological evaluation. However, students pretty much see a cross section of common problems in the setting. Trainees evaluation 2-3 children a month with a wide variety of presenting problems such as delayed intellectual development, poor school performance, behavioral disorders, problematic adaptation to chronic illness, or child abuse and neglect. Assessment procedures are tailored to the referral. Some referrals are relatively discrete and require testing only. More typically, the questions are broader, and may require contacts with staff, interview of the child, parents, and possibly the family. Students also receive experience with projective tests. Specialized assessment procedures for infants, and children with sensori-motor handicaps are commonly used. These assessments also involve other responsibilities including the communication of findings to parents and referrals to other agencies. Although the training experience is primarily devoted to clinical assessment, students also receive some training in interventions appropriate to the setting. For example, one student provided supportive therapy to an eight year old with newly diagnosed ulcerative colitis. Another student is seeing an adolescent girl that she originally evaluated because of an overdose. Supervision for the cases requiring short term intervention is provided in the setting. Longer term case oriented supervision is provided by the department.

Clinical assessments also provide a vehicle for students to learn principles of case oriented consultation. Students communicate with pediatricians and other health care disciplines through informal discussions, notes in the hospital chart, and formal presentations at division conferences. Written psychological reports, which are required in each case, help students communicate information about clinical problems in ways that are useful to other disciplines. Conjoint medical and psychological follow up of selected children and families provides a particularly fruitful training experience. In this way, the young clinician can learn to provide ongoing input to the pediatricians' case management and about the nature of medical treatment for a particular problem. In turn, the pediatrician learns the potentials and limitations of psychological assessment and intervention.

The high level of clinical responsibility assumed by trainees has proven to be a double-edged sword. Although clinical students generally enjoy their active role in patient care, they also feel stressed. The multiple demands of learning clinical assessment and consultation skills are difficult for students to master and require substantial (15-20 hours per week) time commitment in the second year. Supervision in the second year is intensive, ranging from 2-3 hours per week depending on the nature of the clinical problems.

## PROSPECTS

We have now been training students in this model over the past three years. We generally have 2 or 3 first year students for the observational experience. Depending the the fit between their interests and the setting, students may elect to continue for the second year. Because of time pressures, we could train only one student at a time for the second year. We have now expanded and currently have three students for the second year practicum. Thus far, students have generally enjoyed this experience which has served to contribute to their career development. For example, all of the students who have completed the two year experience will pursue careers in child clinical psychology. Some

have remained very interested in medical settings. However, we have not had enough time to gauge the impact of this experience on the long term career development of our practicum students. Another interesting development has occurred with our practicum students who have been able to integrate their clinical and research interests rather closely. The presence of psychology faculty with child developmental interests has been a stimulus for this development (Fagan, 1975). Thus far, all of our practicum students have done or are doing their dissertation research in child development related areas. For example, on her practicum experience one student became interested in children who fail to grow because of environmental factors. Her disseration will involve a study of recognition memory in infants with this problem to help clarify some unanswered questions about the intellectual protential of this intriguing group of infants. We strongly support this kind of integration of students' clinical and research interests by serving on the students' disseration committees and providing guidance with the research. More recently, our practicum experience has become more specialized. Our practicum set up now allows students to obtain more intensive training in certain areas, e.g. such as the psychosocial problems of children with end stage renal failure, or the mental health problems of infants. Students work with the medical staff in these areas and receive a more concentrated dose of clinical experiences with these patient groups. We continue to be impressed with the richness of clinical experiences in the pediatric setting and look forward to continued expansion of training in this area.

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